Bite The Bullet

Under fire for new infections, HIVers confront a crisis worse than any supervirus. But by embracing responsibility for prevention—and facing our demons—we can end the epidemic.

August 1, 2005 By David Evans

We know in our bones what's in store. Despite all our efforts to put a human face on AIDS, HIVers are in danger of becoming as demonized as in the darkest days of the '80s. With the ranks of Americans with HIV now exceeding the one million milestone, the nation is growing impatient throwing money at a preventable epidemic that no one can seem to halt. "You should've known better" is the increasingly common response to new HIVers, many but a step removed from prison, promiscuity and drugs. Nothing illustrates this intolerance better than the media's near-unanimous praise of a published "apology" by Jesse Helms, for many years the most powerful anti-PWA lawmaker in the land: "Until[befriending evangelist Franklin Graham and rocker Bono], it had been my feeling that AIDS was a disease largely spread by reckless…sexual and drug-abusing behavior and that it would probably be confined to those in high-risk populations. I was wrong."

Tragically, we stand at the brink of a potentially epic breakthrough in the science of prevention that could turn the American epidemic around. But this critical development comes at a time when what prevention needs is to free itself from the irrationality and ideology that have long informed it—both the moralizing of Christian conservatives and the moral relativism of liberals—in favor of hard science. Instead, it remains at the volatile center of the culture wars.

The little-publicized research focusing on "sexual networks" is telling us to go right to the epidemic's viral hot spots—and not simply test those high-risk people but launch reality-based interventions that offer carrots rather than sticks (drug treatment, for example, not prison). But most leading civil rights and AIDS organizations lack the political will to risk backing these measures in the face of a Bush administration that owes its reelection to the evangelicals, for whom abstinence funding is payback.

Looking at the prevention through "sexual networks" reveals one immensely significant fact about the epidemic: that a tiny fraction of people with HIV—perhaps less than 5%—keep a particular community's viral wildfire burning. These hot spots are defined not only by sexual connections but by personal problems like addiction and social ills like poverty that dramatically accelerate the spread of HIV. As their staggering HIV infection rates attest, people of color and men who have sex with men are up to five times as likely as the average Joe or Jane to shack up with one of these high-risk core-group members—or, like the crystal meth–addicted gay New Yorker at the center of

the recent supervirus furor, get sucked up into the hot spots themselves. If community-based prevention—including condom and clean-needle distribution—can be said to be a failure, it is precisely because it has failed to adequately reach this crucial 5%. But interventions that expand our grass-roots prevention to include rational public-health measures like partner notification stand a chance—if only our community could embrace and implement them in our own way.

Unfortunately, old fears have prevented us from thinking clearly about such methods. Meantime, we are mired in an argument about whether to disown or protect these hard cases at the heart of the epidemic. Outside our community, a similar argument is taking place between our friends and enemies, one that increasingly centers on the personal responsibility of all HIVers in sex—despite the evidence that the 95% of HIVers outside the viral hot spots have little effect on driving the epidemic. But when has reason ever trumped emotion when it comes to AIDS?

Still, talk of "personal responsibility," however threatening to some HIVers, may be the opening to a new and necessary dialogue. People with HIV alone do have the power to stop new infections—and not only through facing fears of disclosure and always protecting sex partners, as profoundly important as those are. The personal responsibility that is increasingly focused on all HIVers also offers the chance for our community to be leaders once again in prevention.

Failing to do so, we risk being scapegoated—lumped together by an AIDS-weary, moralistic nation as reckless infectors. Given the abstinence-pushing forces ranged against us—from private groups, like Focus on the Family, to the highest government officials—taking charge of, let alone reforming, prevention could take a miracle. But HIVers have made miracles before. In 1983, a few desperate gay men invented "safe sex," cutting new infections so rapidly that public-health experts hailed it as miraculous. That they did so in the face of society's stigma and persecution is even more miraculous.

We can once more find the courage to confront our demons and transform them into salvation. We can fight the urge to back away from new HIVers and to deny that we too know the drug addictions and sexual compulsions of that hard core. Together, we can bite the bullet.

A DANGEROUS NEW PHASE

For a reality check on how bad things are, consider the supervirus case.Last February, New York City's health commissioner, Thomas Frieden, MD,announced that researchers had diagnosed a strain of HIV so aggressive and drug-resistant as to seem untreatable. At a news conference on the steps of City Hall, he declared an official emergency, alerting the public to a dangerous new phase of the pidemic.

As AIDS leaders called for a renewed attack on the scourge of crystal meth among gay men, and public-health experts fanned out to labs nationwide looking for similar infections, the media focused intensively on one particular sexual network, New York's fast-track gays and their meth-fueled unsafe-sex parties. Anti-PWA rhetoric spewed from HIV negative gay journalists, such as Charles Kaiser, who told *The New York Times*, "A person who is HIV positive has no more right to unprotected intercourse than he has the right to put a bullet through another person's head."

Equating HIVers with murderers, Kaiser's "bullet" was the pitch-perfect sound bite, and the press declared open season on risk-taking HIVers. Hearing hate speech from so close to home stunned many HIVers. In June, Canadian gay columnist Richard Burnett added: "If you want to play God, spread HIV and ruin other lives in the process—then do us all a goddamn favor and put a fucking bullet through your head instead."

That the supervirus had been downgraded in the media to a false alarm—no second case was discovered, "Patient Zero" was on treatment and back at work—barely registered. Righteous wrath at irresponsible HIVers was the beat. Veteran journalist Andrew Sullivan says, "Ever since I came out as positive, the hatred has been far more intense from a small cadre of gay activists and journalists than from the religious right. Sometimes I wonder what separates the two with respect to attitudes toward people with HIV."

A TEST FOR POSITIVES

If only Sullivan were right. In fact, the name-calling of gay journalists was so much spilled milk (and ink) compared to the blitzkrieg on condom-based prevention unleashed in recent years by allies of the Bush administration. HIVers and their advocates could, until Election 2000, boast of hard-won places at federal AIDS tables, including the Centers for Disease Control and Prevention (CDC), which funds most of the nation's prevention research. But in the Bush White House, HIV prevention at the CDC became a battleground on which the faith-based movement simply overpowered our AIDS service organizations. Demoted from trusted adviser to outside observer at the CDC, community groups abandoned an emerging critique of our own failing prevention to mount a defense of condoms and frank talk of sex, the two cheapest, most trusted tools of sound prevention policy.

Then, in 2004, the CDC unveiled its Prevention for Positives Initiative, an implicit acknowledgement that the millions of federal dollars spent on a decade-plus of education for low-risk suburban teens and "a condom every time" prevention was a bust—a view the rising new infection rates confirm. But shifting the burden for prevention from the HIV negative to the HIV positive raised red flags for many advocates and experts. Julie Davids, head of the Community HIV and AIDS Mobilization Project (CHAMP), sees this shift as the beleaguered CDC's strategy to keep both conservatives and community activists off its back, but ultimately feels that "what underlies all of this is what happens when you have a government that…doesn't actually believe you can end AIDS."

The CDC's justification sounds benign, contending that since most HIVers do the right thing regarding safe sex—and studies support this safe-sex assumption—the key to controlling infections lies in testing the 250,000 Americans who don't know they are positive. The feds may tout this as a radical new public-health focus, but these measures are neither new nor radical: HIV testing as a "routine" part of medical care and notifying sex partners for those who test positive are decades old. The word condom, however, is suspiciously missing in the CDC's proposal, so in practice, Prevention for Positives often begins—and ends—with testing. As for counseling, care and treatment, the CDC merely "recommends" these services, leaving it an open question where the money for the psychological and physical health of a quarter of a million newly diagnosed

Americans with HIV will come from.

Ana Oliveira, executive director of Gay Men's Health Crisis (GMHC), dismisses the new focus on positives as "simple-minded thinking on HIV testing and names reporting…that you just need to 'test and track' and the epidemic would take care of itself," adding that "HIV prevention [has been driven] into the arms of those who would 'just say no' to sex and drugs."

But Ronald Valdiserri, MD, the deputy director of the CDC's National Center for HIV, STD and TB Prevention, defends shifting the responsibility for prevention to HIVers by pointing out that treatment advances are allowing people with HIV to live longer, have more sex and therefore transmit more HIV. He also disputes the claims of right-wing pressure, saying, "I've been involved with [the new initiative] since day one, and I'm not aware of any influence at all." Prevention for Positives may indeed uncover thousands of new HIVers, but with no commitment to other supports—from condoms to HIV meds—the campaign may also backfire, producing thousands of newly positive who are desperate, confused, angry, hardly the ideal mind-set for taking personal responsibility in sex.

And does Prevention for Positives address that crucial 5% driving the epidemic? Valdiserri claims that his agency not only endorses the science of sexual networks but invented it. "The CDC, especially the STD program, has been aware of sexual networks before the theory even had a name," he says. In fact, the CDC has funded and implemented a number of such studies over the years, but the new initiative uses it only to find new HIVers, not to enlist them in interventions.

"I don't understand why this is just coming to people's attention right now," says Maureen Miller, MD, a pioneering Columbia University researcher. "It should have been on the agenda 15 years ago."

THE RATIONAL IS RADICAL

The dry, almost mathematical details of sexual-network science have always bothered HIVers and other advocates (see "Hot-Spot Science" below).They seem to reduce humanity, psychology, morality to statistics, data ,a dot on a map. Back in the '80s, it also led some scientists and politicians to a simplistic and punitive solution: The best way to stop HIV was to cut the sexual connections—by promoting abstinence or monogamy. For those of us who can't or won't comply, condoms were an unfortunate last resort. A = Abstinence. B = Be Faithful. C=Condoms. Sound familiar?

Some Republicans in Congress proposed a more draconian "solution": Isolate the people with multiple connections through quarantine. A public-health emergency, they claimed, justified the violation of civil liberties.

This willingness to sacrifice the few to save the many was heard often in the early days, and the revelation of how hated HIVers were has traumatized our community. Our prevention leaders wanted nothing to do with this dehumanizing public-health numbers game.

Well, the scientists and numbers people are back with their charts, graphs and a powerful message—one that explains why even our most well-intentioned prevention has failed to stop AIDS. Sexual-network experts describe the epidemic as clusters of people making choices about who to partner with, what degree of risk to take and how they and their partner are connected to the larger network. Most HIV negative people have a low risk, and most HIV positive people pose a low risk, as long as they always use condoms or partner exclusively with others whose status they can be sure of.But whether a person has a lot or a little sex, when they do have condom-free sex with a new partner, everything rides on who that person is. If they're directly connected to a cluster at the center of the network—those who have high-risk sex with many partners, negative and positive—the chance for transmission grows astronomically. At the same time, the closer a person is to the core, the less likely that traditional prevention will reach them. A crystal-meth addict is unlikely to stop for condoms between parties and scoring. A young black woman who needs to keep her man is not likely to demand that he put on a rubber.

Columbia University's Maureen Miller knows all too well how hard it is to change the behavior of people in a sexual network. "The reality for the women I work with in Brooklyn is that there are 40% more women than men, largely because so many men are incarcerated," she says. "This puts women at a disadvantage in negotiating safer sex, as they know that their partner can easily choose to be with another woman."

There's a good chance that this other woman will have a history of crack or heroin use and exchanging sex for drugs or money—and therefore a risk of HIV. In the sexual networks Miller studies, most women have a much higher HIV risk, even those who have never used drugs and are monogamous.

Not all the research is grim, however. Many novel interventions are either in the works or already up and running (see "Hard Core" below). None is the miraculous answer to HIV that was once believed to be coming in "just 10 years" in the form of a vaccine. But they are programs that realistically address the epidemic as we live it today. Though small first steps, they offer hope precisely because they are grounded in the actual risks people take—not the ones that prevention activists or evangelical Christians think they should take.

REACHING—AND REACHING OUT

The ugly truth is that our epidemic is still driven by sexual promiscuity and drug addiction. As this news gets louder and more public, you needn't be psychic or paranoid to predict Jerry Falwell and James Dobson giving impassioned speeches, run hourly on Fox News, to criminalize gay sex in the interests of national security. Fiscal conservatives will argue that it is no longer fair to ask the rest of America to cover expensive HIV meds for people whose deviant behavior made them sick.

Will HIVers then divide into ugly oppositions:the "innocent" infected vs. the "you should've known better," negatives vs. positives, hetero vs. homo? It will be harder than ever for HIVers to speak openly about the complexity of their lives before they were infected. But such honesty is the only corrective to the stereotypes exploited by the morally righteous to justify the scapegoating of HIVers.

Given our nation's growing intolerance,the ability to respect painful differences and speak shameful truths will take courage. But do so we must. Failing to reach—and reach out to—the most despised and irresponsible among us will lead to retribution against all HIVers. After all, so many HIVers were once desperate souls who know what it is to put another person at risk, and with each passing month, a larger majority of newly positive people will be, too. Who better, who else to lead the way?

Hot-Spot Science

The science of sexual networks explores how people are related through sex—and the risk of HIV. While radically reducing our rich humanity to dots on a chart—connected by lines to other dots—the method's power is to offer a bird's-eye view of who is infecting who.

"It has long been known that some contribute much more to the spread of HIV than others. Ignoring that fact hampers our ability to slow HIV/STD transmission," write Dan Wohlfeiler and John Potterat, two research pioneers. This throws light not only on why untargeted, "a condom every time" prevention misses the mark but on the very people and places we must reach—that core 5%—to stop HIV.

Hotspots—whether a sex-worker strip, a needle-shooting gallery, a gay bathhouse, a prison or the 'hood where women outnumber men—share five features:
1. Size: The more people, the faster HIV spreads.
2. Sex: The more sexual links, the faster HIV spreads.
3. The Core: The more people with more partners, the faster HIV spreads.
4. Partner Sharing: The more people with more sex partners at one time, the faster HIV spreads.
5.The Periphery: Sex between people on the periphery, with fewer partners, and those in the core, with many, define the scope of HIV.

Studying hot spots in tandem with such social ills as segregation, stigma, drugs and poverty explains why HIV still rages in the communities of people of color and gay men. Science has advanced us a long way from the old notion that everyone is equally at risk and responsible, but prevention has yet to catch up.

Hard Core

These three interventions offer new ways to access sexual hot spots. None is earth-shattering, but each uses self-interest as an incentive for high-risk, hard-to-reach HIVers—and they work.

1. Kinder, Gentler Partner Notification
University of North Carolina's Adaora Adimora, MD, launched a partner-notification program—a standard public-health measure long resisted by the HIV community—but with a twist. Rather than subject a person who has just tested positive to the sexual third degree, Adimora pays these black women to recruit others for testing. Her program proved nearly five times better at finding

undiagnosed HIVers than the CDC.

2. Get Cash to Get Clean
Similarly, UCLA's Steven Shoptaw, PhD, has found that paying meth-addicted gay men incrementally larger stipends for staying clean over time not only works better as a drug treatment than standard approaches but also dramatically reduces unprotected anal sex. Money talks—especially to folks who have hit bottom. (For more on kicking crystal, see Resources.)

3. A Risk-Reduction pill
Scientists recently confirmed that herpes-2 astronomically increases the risk of giving or getting HIV. So researchers at the University of Washington in Seattle are studying whether blanketing gay communities on the West Coast and HIV hot spots in Africa with acyclovir, a cheap herpes med, will reduce new HIV infections.

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